LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
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FISCAL IMPACT STATEMENT

LS 7086 **DATE PREPARED:** Dec 28, 1998
BILL NUMBER: HB 1366 **BILL AMENDED:**

SUBJECT: Review of HMO Medical Determinations.

FISCAL ANALYST: Alan Gossard
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FUNDS AFFECTED: **X** **GENERAL** **IMPACT:** State
DEDICATED
FEDERAL

Summary of Legislation: This bill establishes that an adverse utilization review or medical necessity determination made by a health maintenance organization (HMO) that conflicts with the patient's attending physician's plan of treatment, is an unfair claim settlement practice. The bill provides for the Commissioner of Insurance to appoint or contract with a physician for review of adverse utilization review and medical necessity determinations. The bill also requires that HMOs provide notice to enrollees or subscribers of the right to file a complaint with the Department of Insurance for review of adverse utilization review or medical necessity determinations that conflict with the patient's attending physician's plan of treatment.

Effective Date: July 1, 1999.

Explanation of State Expenditures: This bill would result in additional expenditures for the Department of Insurance from the requirement that the Commissioner appoint or contract for the services of a "medical complaint professional" who must be a physician. Currently, the Department of Insurance does not have a physician on staff. In addition, depending on future needs, there potentially would be a need for additional legal or clerical services. The cost of hiring or contracting with medical review professionals is estimated to cost about $85,000 annually.

The funds and resources required above could be supplied through a variety of sources, including the following: (1) Existing staff and resources not currently being used to capacity; (2) Existing staff and resources currently being used in another program; (3) Authorized, but vacant, staff positions, including those positions that would need to be reclassified; (4) Funds that, otherwise, would be reverted; or (5) New appropriations. Ultimately, the source of funds and resources required to satisfy the requirements of this bill will depend upon legislative and administrative actions.

The bill also establishes an adverse utilization review determination or an adverse determination of medical necessity as an unfair claim settlement practice. An HMO that committed an unfair claims settlement practice

is subject to one or more of the following: (1) Payment of a civil penalty of not more than $25,000 for each act or violation (but not to exceed an aggregate penalty of $100,000 in any 12 month period). If the HMO knew or reasonably should have known that the HMO was in violation, the civil penalty is $50,000 for each act or violation (but not to exceed an aggregate penalty of $200,000 in any 12 month period). Civil penalties are deposited into the state General Fund.

Thus, the Department of Insurance would incur additional expenses because of the bill, but there could be offsetting penalty revenue into the state General Fund.

Explanation of State Revenues: See Explanation of State Expenditures, above, regarding civil penalties imposed on HMOs that would be determined to have committed an unfair claims settlement practice. Civil penalties are deposited into the state General Fund.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Department of Insurance

Local Agencies Affected:

Information Sources: